Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 78235

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-09-A787-01

MFDR Date Received
JULY 27, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "(ii) Carrier has denied reimbursement for the billed charges stating the services were not authorized. (iii) Professional charges were paid, therefore facility charges should be paid as well. (iv) According to TDI-DWC §134.600, Preauthorization, Concurrent Review, and Voluntary Certification of Health Care, emergency related health care does not require pre-authorization. (c) The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:"

Amount in Dispute: $5,569.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In accordance with §413.014 and §413.0042, as amended in 2005, Health care for an emergency does not require preauthorization; however, the 07/292008 admission to Pine Creek Medical center was not an emergency admission. Please note the following: A) Claimant was injured on 07/10/2008, the surgery date was 07/29/2009. B) The claimant was seen in the emergency room at Sutter General Hospital on 07/10/2008. C) Absent are any emergency room charges to Pine Creek Medical Center on 07/29/2008 and the admission type in Box 14 of the UB04 is listed 9 (unknown). There is no evidence with the documentation provided that this is anything other than a straight forward ***voluntary admission*** without pre-authorization as defined by The TAC §413.0042."

Response Submitted by: Liberty Mutual Insurance Group, 2875 Browns Bridge Rd., Gainesville, GA 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 29 – 30, 2008	Outpatient Hospital Services	$5,569.57	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 18, 2008 and January 19, 2009:
   - 62, X170 – Pre-authorization was required, but not requested for this service per DWC rule 134.600.
   - 150, Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.
   - X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Did the requestor support the services rendered to the injured worker were emergent in nature?
2. Is the requestor entitled to reimbursement?

Findings

1. According to 28 Texas Administrative Code §133.2(a) The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise: (4) Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part… 28 Texas Administrative Code §134.600(p)(2) states that non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services.

   Review of the operative report finds that the postoperative diagnoses were 1) disruption of vastus medialis muscle, left knee; and 2) disruption of quadriceps tendon mechanism and vatus lateralis muscles, left knee. The ICD-9 codes noted on the medical bill were 727.65 - nontraumatic rupture of quadriceps tendon and 727.69 - nontraumatic rupture of other tendon.

   The claimant was injured on July 10, 2008 and was seen in the Sutter General Hospital emergency room the day the injury occurred. The services in dispute were performed 19 days later. Review of the submitted information finds no documentation to support a medical emergency.

2. The insurance carrier denied disputed services with reason code X170 – "PRE-AUTHORIZATION WAS REQUIRED, BUT NOT REQUESTED FOR THIS SERVICE PER DWC RULE 134.600. (X170)" Per 28 Texas Administrative Code §134.600(c) "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." The requestor's letter requesting reconsideration from the carrier states that "On July 28, 2008 Phyllis Howard, the claims adjuster on this case was notified that the injured worker was going to have surgery on the compensable body part and she gave verbal approval." Per §134.600(j) "The insurance carrier shall send written notification of the approval or denial of the request within one working day of the decision to the: (1) injured employee; (2) injured employee's representative; and (3) requestor, if not previously sent by facsimile or electronic transmission. " The requestor did not submit documentation of the written notification of the approval of the authorization request. Review of the submitted information finds insufficient documentation to support the requestor's claim that the services were preauthorized. The insurance carrier's denial reason is supported. Reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August 9, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.